



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 19, 2025

Laurie Pare
Lake (Bloomfield) TRS LLC
6688 N. Central Expressway Suite 1600
Dallas, TX 75206

RE: License #: AH630409730
Investigation #: 2025A0784067
The Avalon of Bloomfield Township

Dear Laurie Pare:

Attached is the Special Investigation Report for the above-mentioned facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

Please review the enclosed documentation for accuracy and contact me with any questions. If I am not available and you need to speak to someone immediately, please contact the local office at (517) 335-5985.

Sincerely,

A handwritten signature in cursive script that reads "Aaron L. Clum".

Aaron Clum, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 230-2778

**MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT**

I. IDENTIFYING INFORMATION

License #:	AH630409730
Investigation #:	2025A0784067
Complaint Receipt Date:	07/10/2025
Investigation Initiation Date:	07/10/2025
Report Due Date:	09/08/2025
Licensee Name:	Lake (Bloomfield) TRS LLC
Licensee Address:	6688 N. Central Expressway Suite 1600 Dallas, TX 75206
Licensee Telephone #:	(214) 754-8623
Administrator/Authorized Representative:	Laurie Pare
Name of Facility:	The Avalon of Bloomfield Township
Facility Address:	100 W Square Lake Rd Bloomfield Twp, MI 48302
Facility Telephone #:	(248) 480-7343
Original Issuance Date:	09/30/2022
License Status:	REGULAR
Effective Date:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	158
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Residents did not receive their medications	Yes
Additional Findings	No

III. METHODOLOGY

07/10/2025	Special Investigation Intake 2025A0784067
07/10/2025	Special Investigation Initiated - Telephone
07/11/2025	Inspection Completed On-site
07/11/2025	Exit Conference Conducted with administrator

ALLEGATION:

Residents did not receive their medications

INVESTIGATION:

On 7/10/2025, the department received this complaint.

According to the complaint, on the morning of 7/08/2025, Residents did not get their morning medications.

On 7/10/2025, I interviewed complainant by telephone. Complainant stated the second floor of the facility has two separate sides with residents living on both sides. Complainant stated that each side has a med cart and that on 7/09/2025, residents on the 200 hall reported they did not receive their morning medications on 7/08/2025. Complainant stated a staff member was present that day to pass medications but did not. Complainant stated the medication administration record (MAR), used to track administered medications in the facilities computer system showed the medications were administered, but that the medications in the cart did not match the record. Complainant stated that the medications are stored in bubble packs with medication for each day of the month and that the medications for 7/08/2025 were still in bubble packs on 7/09/2025 showing consistency with reporting from residents.

On 7/11/2025, I interviewed administrator Lori Pare at the facility. Administrator stated she was not aware of any residents missing medications on the morning of 7/08/2025. Administrator stated a scheduled staff member did call off that morning and that staff 1, a supervisor, worked on the second floor passing medications. Administrator stated that medications for most residents are stored in bubble packs with each number representing the day of the month the medications should be given. Administrator stated that bubble packs for morning medications on 7/08/2025 would be labeled "Morning" for morning medications and that the medication next to the number 8 on the pack should be missing if it was given.

On 7/11/2025, I interviewed staff 1 at the facility. Staff 1 confirmed working on the morning of 7/08/2025 and passing medications on the second floor. Staff 1 stated he was not aware of having missed a pass for any residents.

During the onsite, I reviewed medications for the 200 hall residents. Morning medications for Residents A, B, C and D were still in the bubble packs inside the medication cart for the morning in question.

I reviewed medication administration records (MARs) for Residents A, B C and D, provided by administrator. MARs for Residents A, B and C indicated the morning medications for 7/08/2025 were not given, as was observed in medication cart. The MAR for Resident D indicated his morning medications had been given which was not consistent with what was observed in the medication cart.

APPLICABLE RULE	
R 325.1932	Resident medications.
	<p>(2) The giving, taking, or applying of prescription medications shall be supervised by the home in accordance with the resident's service plan.</p> <p>(3) If a home or the home's administrator or direct care staff member supervises the taking of medication by a resident, then the home shall comply with all of the following provisions:</p> <p style="padding-left: 40px;">(b) Complete an individual medication log that contains all of the following information:</p> <p style="padding-left: 80px;">(ii) The dosage.</p>

ANALYSIS:	The complaint alleged several residents were not administered medications on the morning of 7/08/2025 and that the medications were documented as having been given. While the record was documented, it was documented incorrectly. Based on the findings, the facility is not in compliance with these rules.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, it is recommended that the status of the license remain unchanged.

Aaron L. Clum

8/06/2025

Aaron Clum
Licensing Staff

Date

Approved By:

Andrea L. Moore

08/19/2025

Andrea L. Moore, Manager
Long-Term-Care State Licensing Section

Date